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Decade After Health Care Crisis, Soaring Costs Bring New Strains
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WASHINGTON, Aug. 10 — Ten years after a health care crisis threw American politics into turmoil, many experts see another one looming on the horizon.

The cost of health care, which had stabilized in the mid-1990's with the advent of managed care, is climbing rapidly again, putting new strains on employers, workers and government programs that cover 75 million Americans. In a struggling economy, many employers say they can no longer simply absorb these higher costs and must pass more of them on to employees.

It is not just a problem of rising costs. The troubled economy is expected to cause a rise in the number of Americans without insurance, which stood at 39 million even at the end of the booming 1990's. Families USA, a consumer advocacy group, has estimated that more than 2 million Americans lost their insurance last year because of layoffs.

If the cost of coverage keeps going up, experts warn, even more Americans will join the ranks of the uninsured because they will be priced out of the market. Many health care analysts, their faith shaken in managed care, see no easy fixes.

Politicians in both parties are beginning to respond, but they are profoundly divided on the issue, a deadlock underscored last month by the Senate's inability to pass a prescription drug benefit for Medicare. As a result, the issue is expected to bubble throughout the fall elections.

Behind the numbers are people like Paul McGonnigal, 36, of Portsmouth, N.H., who lost a six-figure salary and his health benefits when his dot.com startup faltered. "I look at this situation as extraordinarily high risk," said Mr. McGonnigal, now trying to start a consulting business with his wife. "We would be financially wiped out if either one of us got seriously ill."

Maryanne McMillan of Richmond, Calif., a city planner disabled by lupus, an autoimmune disease, knows the risk too well. "My credit has gone from good to hell," said Ms. McMillan, who has struggled to piece together affordable coverage. "I feel like I'm on a high wire act when you're the sickest that you could ever imagine being in your life."

The soaring costs are driven, in part, by the biomedical revolution of the past decade, which has produced an array of expensive new treatments for an aging population, from drugs to fight osteoporosis to high-tech heart pumps. The result is a health care system filled with great promise and inequity — such as wonder drugs that many of the nation's elderly must struggle to afford.

Dr. Janelle Walhout sees the paradox every day at the community clinic in Seattle where she works. "I've been thinking lately about the mismatch," Dr. Walhout said, "between how very high-tech medicine has become, with all these genetic tests for everything, mixing your medications like fine cocktails, and our patients, who can't afford them, can't understand it, can't get interpreters to explain it and are just not accessing those things."

After the failure of President Bill Clinton's effort to create universal health insurance in 1994, many experts believed that the private sector — health maintenance organizations and other forms of managed care — would deliver cost-efficient, high-quality medical care. But managed care's success in controlling costs proved short-lived, in part because patients and doctors bristled against its hard bargaining and restrictions on care.

Now, many experts agree with Drew Altman, president of the Kaiser Family Foundation, a health research group, who said: "No one has a big new answer on what to do about health care costs. And it's all made worse because health costs are rising in bad economic times."

The strains in the system are increasingly apparent:

- Spending on health care rose faster in 2000 than at any time since 1993, federal researchers reported this year. Spending on prescription drugs and hospital stays grew particularly fast, largely because of advances in technology and "the retreat from tightly managed care," said Paul Ginsberg, president of the Center for Studying Health System Change, a research organization.

- Health insurance premiums rose an average of 11 percent last year, and are expected to rise another 13 percent this year, after several years of very modest growth. Premiums for many small businesses will rise even higher, many experts say. Calpers, the huge California state employee benefit program, reported that its premiums would rise an average of 25 percent next year.

- Employers are beginning to pass on those higher costs to their workers, in the form of higher copayments and deductibles. According to new studies by the Kaiser Foundation, the amounts that employees pay for deductibles in typical health plans rose by more than 30 percent between 2001 and 2002, after little or no growth in recent years.

"Employers are really trying to get back on track in the current economy," said Kate Sullivan, director of health policy at the United States Chamber of Commerce, adding, "But they are seeing their costs just explode."

Denise Mitchell, director of communications for the A.F.L.-C.I.O., said, "In the last six to nine months, health care has become the biggest issue in collective bargaining."

- States are struggling with soaring costs in their Medicaid programs, which cover more than 40 million low-income Americans. Governors, squeezed by declining tax revenues, are pleading for more money from Washington. State legislatures are coping by cutting benefits, like dental coverage for adults, capping enrollments and requiring poor people to pay more for their care.

Bruce Vladeck, who ran the Medicare and Medicaid programs under President Bill Clinton, describes the situation like this: "The air has gone out of the bubble. We're back into a cycle of cost inflation and an unwillingness, as opposed to the 90's, of employers and to some extent governments to absorb those costs." He added, "They are out of magic bullets."

The picture is not entirely grim. Unemployment is still well below the level it was in the aftermath of the the 1991 recession, when middle-class people, frightened that they would lose their health insurance, pushed the issue to the top of the political agenda and helped defeat the first President Bush. Nor are health care costs rising as rapidly as they

did a decade ago — at least so far. Employers' premiums rose an average of 18 percent in 1989, for example, compared with the 13 percent expected this year.

Moreover, more than two million uninsured children joined the ranks of those covered by insurance since Congress began the Childrens Health Insurance Program in 1997; that reduced the percentage of children without health insurance to 10.8 percent from 13.9.

Tommy G. Thompson, the secretary of health and human services, describes that program as "a genuine success story."

But even Mr. Thompson says the cost squeeze has left the health care system "stretched and stressed." Many health experts now agree with Joel E. Miller, an analyst at the National Coalition on Health Care, made up of business, labor, consumer and other groups. Mr. Miller has been warning that a "perfect storm" could be brewing.

Washington

Lack of Consensus Stalls Major Fix

Mindful of the political power of the health care issue in the past, both Democrats and Republicans are scrambling to claim it as their own.

But the spectacular failure of the Clinton universal care initiative left politicians unwilling to propose another comprehensive plan. Mr. Clinton's attempt to restructure health care became a target for an army of interest groups, failed to pass either the House or the Senate, and is widely considered a major reason his party lost Congress in the 1994 election.

For the remainder of the 1990's, both parties pushed step-by-step efforts to expand health coverage and control costs, an approach known as incrementalism. In that time, the number of uninsured grew slowly, dipping only in 1999 and 2000. Most analysts expect the number to rise again when the Census bureau issues new figures for 2001 in September.

Critics, citing these trends, increasingly say incrementalism has failed.

Among them is the Democratic majority leader, Senator Tom Daschle of South Dakota. Asked if he believed there was a health care crisis, he replied, "Absolutely." Mr. Daschle said he was not wedded to any particular plan, but believed the incremental approach was not enough. "We've got to revisit the issue at a national level," he said.

Mark McClellan, a member of the President's Council of Economic Advisors and the chief adviser in the White House on health, acknowledged, "It is harder for people to get care, the best care, at prices they can afford."

But Dr. McClellan refuses to write off the step-by-step approach. "People who are waiting for the day of a big universal coverage system coming in and taking over all aspects of our health care system are going to be waiting for a long time," he said, "because there's no consensus in this country to do that now."

Indeed, the lack of consensus has bedeviled those trying to tackle health care, and the narrowly divided Congress has consistently deadlocked on the issue in recent years. Lawmakers have spent much of the past three years trying — and failing — to pass legislation giving the 40 million elderly and disabled Americans on Medicare some basic relief for the cost of prescription drugs. The two parties also deadlocked on an economic stimulus package that would have provided assistance to laid-off workers trying to keep their health insurance.

The Bush administration has proposed a number of initiatives, including tax credits to help the uninsured purchase private coverage, which the White House estimates could result in covering eight million Americans. The administration also backs legislation to change the way medical malpractice lawsuits are handled — a step the White House says is necessary to control health costs, including doctors' malpractice premiums.

"What we would like to do is find ways to keep health care affordable while at the same time preserving the U.S. leadership in delivering high quality health care, Dr. McClellan said. "And that is a difficult challenge."

But Mr. Daschle describes the Bush administration as "AWOL" on health care. Democrats in general argue that the administration's tax credits for buying insurance are not nearly enough to reduce the ranks of the uninsured. They tend to support expanding the existing government programs — anathema to many Republicans, who support private sector solutions.

The rise in health costs, coupled with the sudden disappearance of the federal budget surplus, make it all the harder to undertake a major program.

Some political strategists are beginning to see a growing gap between Washington's inability to act and the public's clamoring for relief. Bill McInturff, a Republican pollster, says that in many ways the prescription drug issue is a proxy for the rising concern among voters over the cost of health care generally.

"We keep postponing a larger national debate about a health care system that's far from perfect," Mr. McInturff said, "because it's hard."

Senator Hillary Rodham Clinton of New York acknowledges as much. "People are saying we've got to go back and take a look at this, and I think it needs to be done," Senator Clinton said. But the woman who, as the president's wife, produced a 1,342-page plan to restructure the health care system in 1994 now says, "I don't have a detailed road map on how to get there."

Families

Coverage Cost Climbs Out of Reach

From factory workers to business executives, Americans are trying to cope with higher health costs. Those who feel it most acutely are people who do not have subsidized group insurance from their employers.

In Nacogdoches, Tex., David and Nicole Alders, who own a small poultry farm and must buy their own coverage, have seen their premiums double over the past five years. To keep costs down, the couple took a policy with a \$15,000 deductible.

"I'm concerned about what will happen five years from now if it doubles again," Mr. Alders said. "A 20 percent annual increase when I'm 40 years old is going to be unaffordable when I'm 60."

In Leesburg, Va., Dale Gardner, who became an independent consultant when he lost his software marketing job, pays \$953 a month to cover his family under the federal Cobra program, which allows laid-off workers to keep their benefits for up to 18 months. But as the 18 months comes to a close, Mr. Gardner's wife is considering going back to work — not for the money, he said, but for the insurance.

In Massapequa, N.Y., Trish Patafio, a homemaker, and her husband, Bob, who is self-employed and moves boats for a living, saw their premiums rise to \$759 from \$559 a month. So the Patafios enrolled their three children in the federally subsidized Children's

Health Insurance Program, or CHIP, available to families that earn up to twice the federal poverty level, or about \$34,000 a year.

Even so, Mrs. Patafio said, the couple must pay \$514 a month to insure themselves. "We're eating pancakes some nights as it is," she said. "I said to my husband, 'What are we going to do, sell the house so we can pay health insurance?'"

For many, any coverage is out of reach. Dolores Stanfield, a 50-year-old waitress in Columbia, S.C., has not had health insurance for 15 years. She makes do with a subsidized clinic, but still has \$3,000 in outstanding bills at the local emergency room; a serious illness could put her in debt for life.

About 14 percent of Americans, the vast majority in working families, lack health coverage either because their employers do not offer it or it costs too much. They may earn too much to qualify for government health assistance, or they may be childless adults, and thus ineligible for many programs.

Ron Pollack, the executive director of Families USA, says that in 43 states a person without children can be penniless and still fail to qualify for federally subsidized health coverage. Mr. Pollack argues eligibility for public programs should be based on income, not family status.

"This is a political pecking order," Mr. Pollack said, "that somehow children are more popular than parents and parents are more popular than nonparental adults."

That pecking order plays out significantly in the lives of the Everett family of Arlington, Tex.: Corrine, who has multiple sclerosis, her husband, Cliff, who works for a company that offers insurance the family cannot afford, and their two children, ages 12 and 18.

The entire family went without health coverage until two years ago, when the children were enrolled in CHIP. But the parents do not qualify for government help. "He makes too much money for us to get on Medicaid," Mrs. Everett said, "but he doesn't make enough money for us to be able to afford insurance."

Mrs. Everett turned up in the emergency room on a Saturday night three years ago, her arm so numb she could not lift it.

Delaying treatment is typical of the uninsured, according to the Institute of Medicine, an independent research organization. In a recent report, the institute concluded that as many as 18,000 Americans die prematurely each year as a result of not having health coverage. Many wait too long to receive treatment.

Mrs. Everett was referred to a neurologist, Dr. Rizwan Shah, who prescribed medicine that costs \$1,000 a month and then helped enroll her in a charity program sponsored by the drug's maker. If her disease flares up, Dr. Shah admits her to the hospital, he said, but always through the emergency room, because emergency rooms are required by law to treat people regardless of whether they can afford to pay. This strategy is more costly, he said, "but I have no other choice."

With tears in her eyes, Mrs. Everett told how Dr. Shah charges her only what she can afford to pay. "If he moves on or retires, I'm without a doctor," she said. "I'm not going to find another doctor to do what he does for me."

Employers

Trying to Turn Profit as Basic Cost Soars

The rising cost of health care has created a complicated blame game among the main players in the system. Patients are blamed for wanting too much care and being

heedless of the costs. Managed care companies are blamed for not delivering what they promised: high quality, tightly managed medicine.

Doctors and other health care providers are blamed for "provider pushback" — resisting limits on treatment and asserting their bargaining clout for higher reimbursements. Politicians are blamed for undermining these limits by mandating certain benefits and rights of appeal.

In the middle of it all are the employers, who provide health insurance to two-thirds of all Americans under 65. Sears Roebuck & Company provides a glimpse into how businesses are coping.

Sears has always prided itself on offering what Liz Rossman, vice president for benefits, calls "a high level of coverage." When managed care first arrived in the early 1990's, promising affordable quality care by focusing on prevention and close management of medical services, the company bought into the idea. It joined an employer group that negotiated with different insurers.

Health maintenance organizations became the insurers of choice at Sears; by the end of the decade, the company was offering about 500 different H.M.O. plans, about a half dozen for each of its locations. Ms. Rossman said 87 percent of the company's 275,000 employees were enrolled.

"Our employees were very, very happy," she said. "It was obviously something that worked."

But about two years ago, Sears officials noticed costs were creeping up again. This year, Ms. Rossman said, some plans are asking for as much as a 50 percent increase. The company dropped the most expensive plans, and at the same time began offering a plan for all employees under which they pay a percentage of their care but have more leeway in choosing their doctors. So far, Ms. Rossman said, the plan is more cost-efficient. Enrollment in traditional H.M.O.s is now down to 44 percent of the Sears workforce.

Ms. Rossman blames insurance companies, saying "most plans didn't have the computer systems or real controls" to manage care and keep costs down.

But Karen Ignagni, president of the American Association of Health Plans, which represents managed care companies, says the rise in health premiums results from a complex tangle of factors, from the increased health care needs of an aging population to advances in medical technology.

Ms. Ignagni resists the argument that managed care has been a failure. She said the system could have succeeded in keeping costs down, had it not been for the rebellion by doctors and other advocates, who fought restrictions on care by lobbying elected officials to require insurers to cover certain tests and procedures, regardless of the cost or whether there is scientific evidence to justify them.

A recent report by Pricewaterhouse Coopers, prepared for Ms. Ignagni's group, says such government mandates are responsible for 15 percent of the recent rise in health care costs.

"There is a political dynamic here," Ms. Ignagni said, adding, "It's all about lobbying."

Not surprisingly, doctors disagree. Dr. Richard Corlin, a former president of the American Medical Association, cited "advancing technology and an aging population," along with the rapid increases in the cost of malpractice insurance, as the primary reasons

for the rising cost of care. The A.M.A. also notes that insurance companies are reaping higher profits.

Companies like Sears have been coping with the price increases by asking employees to pick up a larger share of the cost of their coverage, in the form of higher deductibles and co-payments. Health care economists call this tactic cost-shifting.

Government actuaries predict that cost-shifting will help slow spending increases later in the decade.

Ms. Sullivan, the health policy expert for the Chamber of Commerce, argues that cost-shifting is not necessarily a bad thing, because it forces patients to take responsibility for what they spend on care. "The patient starts acting like a consumer," Ms. Sullivan said.

Maybe so, says Dr. Ginsburg, of the Center for Studying Health System Change, but sometimes they make bad health care choices in the interest of saving money. "What I worry about," he said, "is cost-sharing becoming a barrier to people getting the care they need."

Even Ms. Sullivan says that if employees are asked to pick up too much of the cost, they and their families will simply drop out of employer-sponsored plans, "voluntarily uninsuring themselves."

That is how Adela Velasquez, a part-time housekeeper in San Rafael, Calif., became the only member of her family without health insurance.

Her husband, Francisco Guillen, works for a construction company that offers health benefits to its employees, and picks up part of the cost for their families. But the policy is a so-called tiered plan, one that assigns different costs to different family members.

Insuring the children was a bargain, only \$138 per year. But adding Ms. Velasquez to the policy would have cost \$3,250 a year.

So Ms. Velasquez roams the pharmacy aisles looking for low-cost over-the-counter remedies when she is sick and visits the doctor only rarely. A year ago, she noticed a painful lump in her groin, but she waited six months before seeking treatment at a public clinic.

For \$60 cash, a doctor examined her and diagnosed a hernia, a tear of the groin muscle wall. But the surgery to repair it would cost \$7,000, which Ms. Velasquez did not have. Eventually, a volunteer surgeon working for a private charity performed the operation free.

"We are all healthy, thank God," Ms. Velasquez said, speaking in Spanish through an interpreter. But she added, "For me, there is no insurance."

States

Medicaid Is Choice for Cutting Costs

For decades, the federal and state governments have been the insurer of last resort for the youngest, oldest and sickest Americans. But the government's safety net programs are under increasing strain, in part because of recent efforts to cover more low-income families.

Nowhere is that strain more apparent than in the states.

Medicaid, the state-administered health insurance program for low-income people, covers one in seven Americans. It pays for 40 percent of the births in the nation and 50 percent of the nursing home bills. It is already the second largest item in state

budgets, second only to education — and it is growing fast — with state spending on Medicaid up 13 percent last year, according to the National Governors Association.

Even in good times, Medicaid costs would be a burden, and these are not good times. Governors in both parties have been making panicky appeals for more help from the federal government, which pays an average of 57 percent of the Medicaid costs.

But the Bush administration, citing its own budget problems, has rejected those appeals, offering, instead, to grant states additional flexibility to stretch their dollars. Utah, for example, recently received a federal waiver to reduce benefits to poor people currently on the rolls so that more low-income people could be offered a bare-bones health package. Mr. Thompson said he had approved 1,950 waivers in his less than two years in office.

Almost every state is tinkering with benefits in an attempt to control costs. Some are raising co-payments and requiring the use of generic drugs. Some are freezing payments to doctors and hospitals.

Fourteen states are cutting other benefits, like dental care for adults. Most are looking at how to contain spending for prescription drugs, which rose an average of 19.7 percent in the last two years.

Washington State, for example, prided itself on expanding — not contracting — coverage throughout the 1990's. Nearly one in three children in the state are now served by Medicaid and the Children's Health Insurance program, and the state has one of the highest rates of overall health insurance in the country.

But the days of expansion are over. With the state facing a severe budget shortfall, Mr. Braddock is proposing a variety of cost controls on Medicaid that have prompted a wrenching debate.

People would be charged a \$5 co-payment if they wanted certain brand-name drugs instead of the generic versions, for example, or a \$10 co-payment if they used an emergency room for nonemergency care. The state would also be allowed to cap enrollment in part of its program, although the poorest would continue to receive health care as an entitlement.

"In general, nobody liked any of the strategies," said Doug Porter, assistant secretary, medical assistance administration, at the Department of Social and Health Service, after a round of public hearings. "They got very quickly to the human costs."

Already, many doctors are declining to accept Medicaid patients because they say the payments are too low. At the Rainier Park Medical Clinic in Seattle, doctors say that they must sometimes scramble to find specialists who will see their Medicaid patients. Dr. Colin Romero was so grateful to one ophthalmologist who regularly takes his referrals that he said he was thinking of writing a thank-you note.

Future

Forbidden Factor May Be Necessity

On a sticky, rainy afternoon in late July, President Bush took the podium at a university gymnasium in North Carolina and greeted about 1,700 doctors, nurses and other health care professionals. Mr. Bush had come to propose changing the medical malpractice system. But the backdrop behind him, which read "Strengthening Health Care: Access, Affordability, Accountability," suggested the White House had a broader message in mind.

"Right now, rising health care costs are undermining the availability of health care, of medical care not only here in North Carolina, but throughout our country," the president said. "And the rising costs were forcing too many people to go without, and that's not right, that is a problem."

The scene was eerily evocative of 1992, when Bill Clinton took on the problem of rising health costs and promised every American the right to affordable care. The Bush administration is proposing nothing so bold, but its officials, keenly aware of how this issue hurt the president's father, are careful to voice their concern.

As Mr. Thompson, the secretary for health and human services, said in a recent interview, "Health care is costing so much, along with prescription drugs, that Congress and this administration have got to address it."

But the question of how to address it is very hard for a society with an insatiable appetite for the newest and most expensive drugs and treatments and a deep resentment of any proposal that would limit their health care choices.

That resentment was largely responsible for the death of the Clinton plan, which was brought down, in part, by the fear of government rationing — having elected officials (or their bureaucrats) deciding which tests and procedures are covered and which are not. A few years later, the fear of rationing by private corporations — H.M.O.'s and other insurance companies — ignited a patient rebellion against managed care.

Many health policy experts argue that tackling health care inflation will require a fundamental cultural shift in the American approach to medicine. They say doctors and patients must begin taking cost into account when making treatment decisions. They say Americans must limit themselves to treatments that are proven to work and accept the premise that more care does not necessarily mean better care.

"As a society, sooner or later we will have to determine whether there are some benefits that are too plain small to justify the cost," said David Eddy, an independent analyst who advises health care organizations, including the managed care industry. Americans, he said, "have an enormous tendency to use treatments if we think they work or if we hope work, even if there is no evidence that they do work."

In the 1990's, for instance, bone marrow transplants were widely used to treat aggressive breast cancer. Then studies showed it was no better than standard therapy. Hormone replacement therapy, prescribed to millions of American women, has now been discredited as a way to prevent heart disease and stroke.

Dr. Eddy says he believes a new government agency should be set up to take this kind of scientific literature into account, and then make recommendations about whether new treatments are worth the cost. But while health experts agree there is a critical need for independent evaluations of new technologies, they doubt such an agency will ever come into existence.

"It would be killed by all the lobbying groups," said Uwe Reinhardt, a health economist at Princeton University.

Because Americans cannot agree as a society on what is worth covering — or even whether health care is a basic right — individual families have been left to make their own decisions about what kind of health care they can afford. Those decisions, in the end, are framed by the family's economic situation, Professor Reinhardt said, creating a system with too little care for families near the bottom and often too much for families near the top.

Mr. Reinhardt is one of many experts who argue that such a system is neither efficient nor just.

No one sees this more clearly than the nation's doctors, among them Dr. Bartolo Barone, a neurosurgeon in Charleston, S.C. When he rotates through his hospitals emergency room, Dr. Barone said, he sees a system that simply does not make sense.

"We're seeing the consequences of people who are going without their medications for diabetes or high blood pressure," Dr. Barone said. "They are paying the rent, they are buying what the kids need, and they skimp on the medicine. I see the stroke, the heart disease, the expensive consequence of disease that hasn't been properly controlled. If you're worried about controlling costs in health care, this is a foolish way to do it."

But health experts say they are not sure about what comes next.

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